Simplifying Administrative Data Exchange, Interoperability at the CORE

On the Road to Interoperability: CORE Phase I Rules Certification Testing

The 13th National HIPAA Summit

Washington, DC

Monday, September 25, 2006

Discussion Topics

- Overview of CAQH and CORE
- CORE Certification Testing: Becoming CORE Phase I Certified

Presenters

- Gwendolyn Lohse, CORE Project Director, CAQH
- Rachel Foerster, CORE Consultant, Boundary Information Group

An Introduction to CAQH

CAQH, a nonprofit alliance of leading health plans, networks and trade associations, is a catalyst for industry initiatives that streamline healthcare administration

CAQH solutions help:

- Promote quality interactions between plans, providers and other stakeholders
- Reduce costs and frustrations associated with healthcare administration
- Facilitate administrative healthcare information exchange
- Encourage administrative and clinical data integration

Example of CAQH initiatives: Credentialing and CORE

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Committee On Operating Rules For Information Exchange

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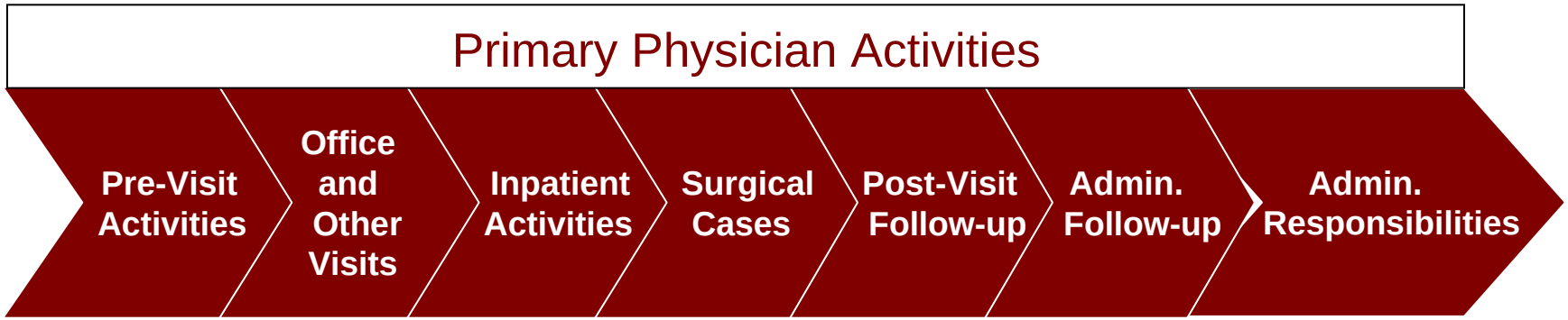
Physician-Payer Interaction

Physician Activities That Interact With Payers are Primarily Administrative in Nature (with Some Clinical Interaction)



- Patient inquiry
- Appt scheduling
- Scheduling verification
- Financial review of pending appts.
- Encounter form/ medical record preparation

- Registration & referral mgmt.
- Admin & medical record preparation
- Patient visit
- Ancillary testing
- Charge capture
- Prescriptions

- Scheduling & referral mgmt.
- Admin & medical record preparation
- Inpatient care
- Ancillary testing
- Charge capture

- Scheduling & referral mgmt.
- Admin & medical record preparation
- Surgical care
- Post care
- Follow-up care

- Visit orders & instructions
- Education materials
- Prescriptions
- Ancillary tests
- Referrals
- Follow-up visits

- Utilization review
- Claims/bill generation
- Billing
- Payment processing
- Claims follow-up

- Personnel management
- Financial management
- Managed care
- Information systems
- Facilities management
- Medical staff affairs

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Key Challenges: Eligibility and Benefits

- HIPAA does not offer relief for the current eligibility problems
  - Data scope is limited; elements needed by providers are not mandated
  - Does not standardize data definitions, so translation is difficult
  - Offers no business requirements, e.g., timely response
- Individual plan websites are not the solution for providers
  - Providers do not want to toggle between numerous websites that each offer varying, limited information in inconsistent formats
- Vendors cannot offer a provider-friendly solution since they depend upon health plan information that is not available

Vision: Online Eligibility and Benefits Inquiry

Give Providers Access to Information Before or at the Time of Service...

Providers will send an online inquiry and know:

- Which health plan covers the patient *
- Whether the service to be rendered is a covered benefit (including copays, coinsurance levels and base deductible levels as defined in member contract)
- What amount the patient owes for the service**
- What amount the health plan will pay for authorized services**

Note: No guarantees would be provided

* This is the only HIPAA-mandated data element; other elements addressed within Phase I scope are part of HIPAA, but not mandated

** These components are critically important to providers, but are not proposed for Phase I

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Vision: Online Eligibility and Benefits Inquiry

… Using any System for any Patient or Health Plan

As with credit card transactions, the provider will be able to submit these inquiries and receive a real-time response*

- From a single point of entry
- Using an electronic system of their choice

- For any patient
- For any participating health plan

*Initiative will initially support batch and real-time

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CORE

- Industry-wide stakeholder collaboration
- Short-Term Goal
  - Design and lead an initiative that facilitates the development and adoption of industry-wide operating rules for eligibility and benefits
- Long-Term Goal
  - Based on outcome of initiative, apply concept to other administrative transactions
- Answer to the question: *Why can't verifying patient eligibility and benefits in providers' offices be as easy as making a cash withdrawal?*

CORE Mission

To build consensus among the essential healthcare industry stakeholders on a set of operating rules that facilitate administrative interoperability between health plans and providers

- Build on any applicable HIPAA transaction requirements or other appropriate standards such as HTTPS
- Enable providers to submit transactions from the system of their choice and quickly receive a standardized response from any participating stakeholder
- Enable stakeholders to implement CORE phases as their systems allow
- Facilitate stakeholder commitment to and compliance with CORE's long-term vision
- Facilitate administrative and clinical data integration

Key things CORE will not do:

- Build a database
- Replicate the work being doing by standard setting bodies like x12 or HL7

CORE Guiding Principles

- All CORE Participants and CORE-certified entities will work towards achieving CORE's mission.
- All stakeholders are key to CORE's success; no single organization, nor any one segment of the industry, can do it alone.
- CAQH will strive to include participation by all key stakeholders in the CORE rule making process. CORE has established Governing Procedures; under these Procedures, each CORE member that meets CORE voting criteria will have one vote on CORE issues and rules.
- CAQH serves as the facilitator, while CORE participants draft and vote on the rules.
- Participation in CORE does not commit an organization to adopt the resulting CORE rules.
- Use of and participation in CORE is non-exclusive.
- CORE will not be involved in trading partner relationships, and will not dictate relationships between trading partners.
- To promote interoperability, rules will be built upon HIPAA, and CORE will coordinate with other key industry bodies (for example, X12 and Blue Exchange).
- Whenever possible, CORE has used existing market research and proven rules. CORE rules reflect lessons learned from other organizations that have addressed similar issues.
- CORE rules will support the Guiding Principles of HHS's National Health Information Network (NHIN).
- Where appropriate, CORE will address the emerging interest in XML.
- CAQH research indicated that there will be benefit to the health care industry as a result of adopting eligibility operating rules. CORE will have Measures of Success for Phase I (methodology to measure success and evaluate market impact) and CAQH will report aggregate findings by stakeholder type. Full benefits may not be experienced until Phase II.
- CORE will provide guidance to stakeholders regarding staff implementation and training needs.
- Safeguards will be put in place to make sure that a health plan's benefit and payment information is shared only with the requested provider and is not available to other participating health plans.
- CORE will not build a switch, database, or central repository of information.
- All CORE recommendations and rules will be vendor neutral.
- All of the Phase I rules are expected to evolve as Phase I is a starting point.
- Rules will not be based on the least common denominator but rather will encourage feasible Phase I progress.
- CORE will promote and encourage voluntary adoption of the rules.
- CORE participants do not support "phishing."

What Are Operating Rules?

- Agreed-upon business rules for using and processing transactions
- Encourages the marketplace to achieve a desired outcome – interoperable network governing specific electronic transactions (i.e., ATMs in banking)
- Key components
  - Rights and responsibilities of all parties
  - Transmission standards and formats
  - Response timing standards
  - Liabilities
  - Exception processing
  - Error resolution
  - Security

Examples of the use of operating rules in other industries

Current Participants

- Over 85 organizations participate representing all aspects of the industry:
  - 16 health plans
  - 11 providers
  - 5 provider associations
  - 18 regional entities/RHIOS/standard setting bodies/other associations
  - 28 vendors (clearinghouses and PMS)
  - 7 others (consulting companies, banks)
  - 5 government entities, including:
    - Centers for Medicare and Medicaid Services
    - Louisiana Medicaid – Unisys
    - TRICARE
- CORE participants maintain eligibility/benefits data to nearly 125 million commercially insured lives, plus Medicare beneficiaries

Current Participants

Health Plans

- Aetna, Inc.
- Blue Cross Blue Shield of Michigan
- Blue Cross and Blue Shield of North Carolina
- BlueCross BlueShield of Tennessee
- CareFirst BlueCross BlueShield
- CIGNA
- Excellus BlueCross BlueShield
- Group Health, Inc.
- Health Care Service Corporation
- Health Net, Inc.
- Health Plan of Michigan
- Humana, Inc.
- Independence Blue Cross
- Kaiser Permanente
- UnitedHealth Group
- WellPoint, Inc.

Government Agencies

- Louisiana Medicaid – Unisys
- Michigan Department of Community Health
- Michigan Public Health Institute
- TRICARE
- United States Centers for Medicare and Medicaid Services (CMS)

Associations / Regional Entities / Standard Setting Organizations

- America's Health Insurance Plans (AHIP)
- ASC X12
- Blue Cross and Blue Shield Association (BCBSA)
- CalRHIO
- Delta Dental Plans Association
- eHealth Initiative
- Health Level 7 (HL7)
- Healthcare Information and Management Systems Society (HIMSS)
- Healthcare Financial Management Association (HFMA)
- Maryland/DC Collaborative for Healthcare IT
- National Committee for Quality Assurance (NCQA)
- National Council for Prescription Drug Programs (NCPDP)
- NJ Shore (WEDI/SNIP NY Affiliate)
- Private Sector Technology Group
- Smart Card Alliance Council
- Utah Health Information Network (UHIN)
- Utilization Review Accreditation Commission (URAC)
- Work Group for Electronic Data Interchange (WEDI)

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Current Participants

Other
- ABN AMRO
- Accenture
- Data Processing Solutions
- Foresight Corporation
- Marlabs, Inc.
- PNC Bank
- PricewaterhouseCoopers LLP

Providers
- Adventist HealthCare, Inc.
- American Academy of Family Physicians (AAFP)
- American College of Physicians (ACP)
- American Hospice, Inc.
- American Medical Association (AMA)
- Catholic Healthcare West
- Greater New York Hospital Association
- HCA Healthcare
- Laboratory Corporation of America (LabCorp)
- Mayo Clinic
- Medical Group Management Association (MGMA)
- Montefiore Medical Center of New York
- Partners HealthCare System
- University of Wisconsin Medical Foundation (UWMF)
- University Physicians, Inc. (University of Maryland)

Vendors
- ACS State Healthcare
- Affiliated Network Services
- Athenahealth, Inc.
- Availity LLC
- CareMedic Systems, Inc.
- Edifecs
- Electronic Data Systems (EDS)
- Electronic Network Systems, Inc. (ENS)
- Emdeon
- First Data Corp. – Healthcare
- GHN-Online
- Healthcare Administration Technologies, Inc.
- HTP, Inc.
- McKesson
- MedAvant Healthcare Solutions
- MedCom USA
- MedData
- Microsoft Corporation
- NaviMedix
- Passport Health
- Post-N-Track
- Quovadx
- RxHub
- Siemens / HDX
- SureScripts
- The TriZetto Group, Inc.
- ViPS (a Division of Emdeon)

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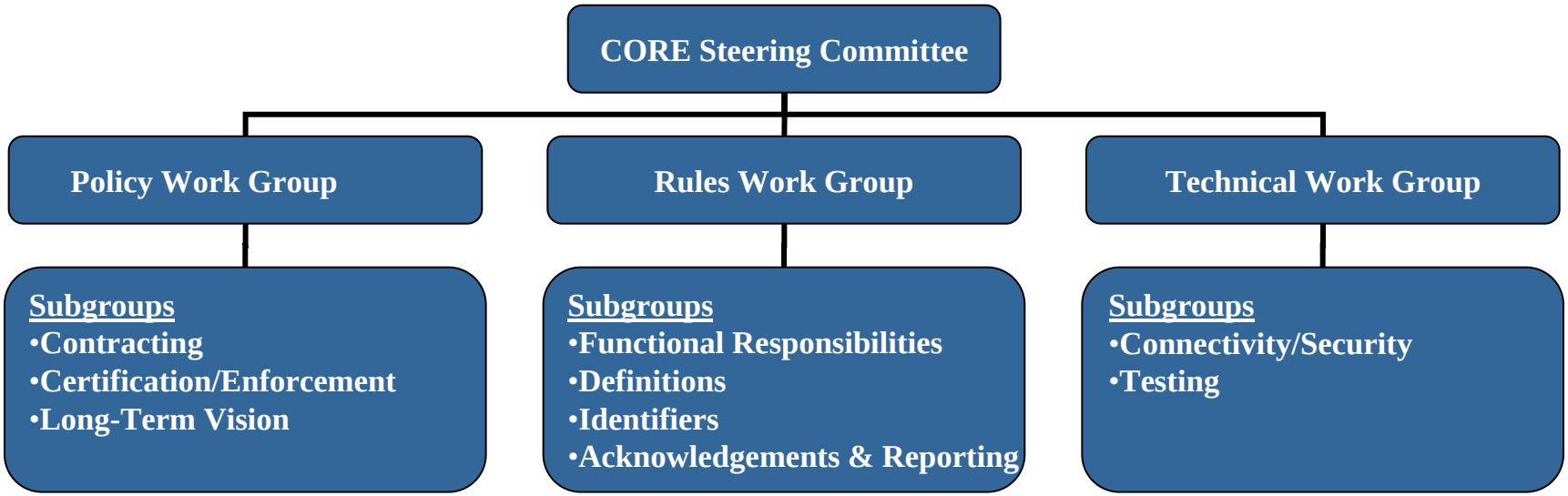
CORE Work Groups And Subgroups



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CORE Leadership

POSITION	COMPANY	INDIVIDUAL
Chair	BCBSNC	Harry Reynolds, Vice President
Vice Chair	HCA	Eric Ward, CEO of Financial Services
Policy Work Group Chair	Humana	Bruce Goodman, Senior Vice President & CIO
Rules Work Group Chair	PNC Bank	J. Stephen Stone, SVP & Director of Product Management
Technical Work Group Chair	Siemens	Mitch Icenhower, Director, HDX
At Large Members: Health Plan 1	Aetna	Paul Marchetti, Head of Network Contracting, Policy and Compliance
At Large Members: Health Plan 2	BCBSMI	Deborah Fritz-Elliott, Director, Electronic Business Interchange Group
At Large Members: Vendor Org.	TriZetto	Dawn Burriss, Vice President, Constituent Connectivity
At Large Members: Provider Organization	Montefiore	J. Robert Barbour, JD, Vice President, Finance for MD Services and Technical Development
At Large: Other Organization	HIMSS	H. Stephen Lieber, President & CEO

Other (Ex-officio or Advisor):
CAQH: Robin Thomashauer, Executive Director; **CMS**: Stanley Nachimson, Senior Technical Advisor, Office of E-Health Standards and Services; **ASC X12**: Donald Bechtel, Co-Chair, X12 Healthcare Task Group (also with Siemens); **WEDI**: Jim Schuping, Executive Vice President; **NACHA**: Elliott McEntee, President and CEO; **Health Level 7 (HL7):** John Quinn, Chair, HL7 Technical Steering Committee

CORE Phase I Certification & Endorsement Commitments

- Please reference the **9/15/06** Press Release handout.

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CORE Phase I Education Sessions

In-person Workshops:

- Thursday, September 27th, 1:00-5:00pm ET, HIPPA Summit
- Thursday, November 9, 2006, time TBD, Phoenix, AZ

Audiocast Workshop:

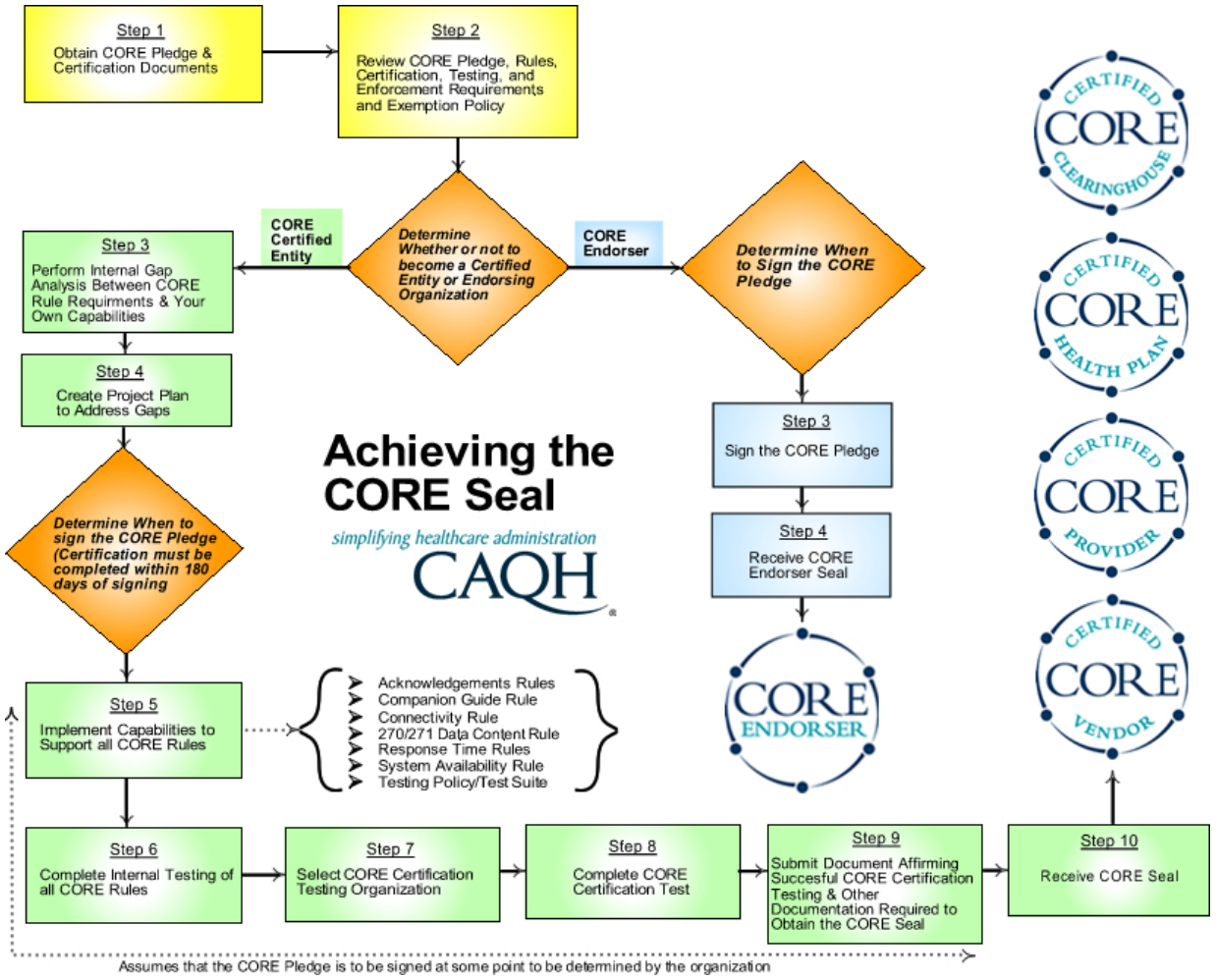
- Thursday, October 19th, 2006, 2:00-3:30pm ET

CORE Phase I Certification

CORE-Certification

- Recognizes entities that have met the established operating rules requirements
- Entities that create, transmit or use eligibility data in daily business required to submit to third-party testing (within 180 days of signing pledge); if they are compliant, they receive seal as a CORE-certified health plan, vendor (product specific), clearinghouse or provider
- Entities that do not create, transmit or send – sign Pledge, receive CORE Endorser Seal

Achieving the CORE Seal



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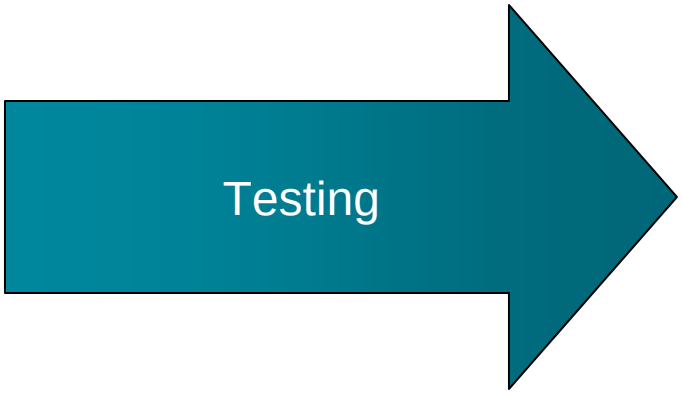
CORE Pledge

- CORE certification is voluntary
- Binding “Pledge”
- By signing Pledge, CORE entities agree to adopt, implement and comply with Phase I eligibility and benefits rules as they apply to each type of stakeholder business
- The Pledge will be central to developing trust that all sides will meet expectations
- Organizations have 180 days from submission of the Pledge to successfully complete CORE-certification testing

Real World Impact

- Provides mechanism to identify practice management vendors, clearinghouses and plans that are CORE-certified and, thus, to the best of CORE's knowledge, compliant with the rules
- Sends a clear signal that compliance with administrative transactions is important and that there is a process to remove non-compliant organizations
- Enables vendors to differentiate themselves to offer improved products
- Publicly communicates the seriousness of this voluntary effort

Real World Impact



- Informs the industry that CORE-certified entities not only support their stakeholder-specific rules but have also implemented the required capabilities
- Provides a reasonable building block towards industry-wide conformance testing (and validation) for administrative transactions

Phase I testing was not designed to be exhaustive, e.g. no volume capacity testing

CORE Certification Seals

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CORE Seal Fees

Health Plans

• Below $75 million in net annual revenue	$4,000 fee
• $75 million and above in net annual revenue	$6,000 fee

Vendors

• Below $75 million in net annual revenue	$4,000 fee
• $75 million and above in net annual revenue	$6,000 fee

Providers

• Up to $1 billion in net annual revenue	$ 500 fee
• $1 billion and above in net annual revenue	$1,500 fee

Endorser (only for entities that do not create, transmit or use eligibility data; or small providers) — No fee

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CORE Phase I Certification Testing

CORE Phase I Rules

- **Data Content**
  - Patient Responsibility (co-pay, deductible, co-insurance levels in contracts – not YTD)
  - Service Types (9 for Phase I)
- **Connectivity**
  - HTTP/S Safe harbor
- **Response Time**
  - Batch (In by 9:00pm ET, response by 7:00am ET next day)
  - Real-time (20 seconds or less)
- **System Availability**
  - 86% per calendar week for batch and real-time
- **Acknowledgements**
  - TA1, 997, 271
- **Companion Guide**
  - Flow and format standards

CORE-Certification Testing Steps

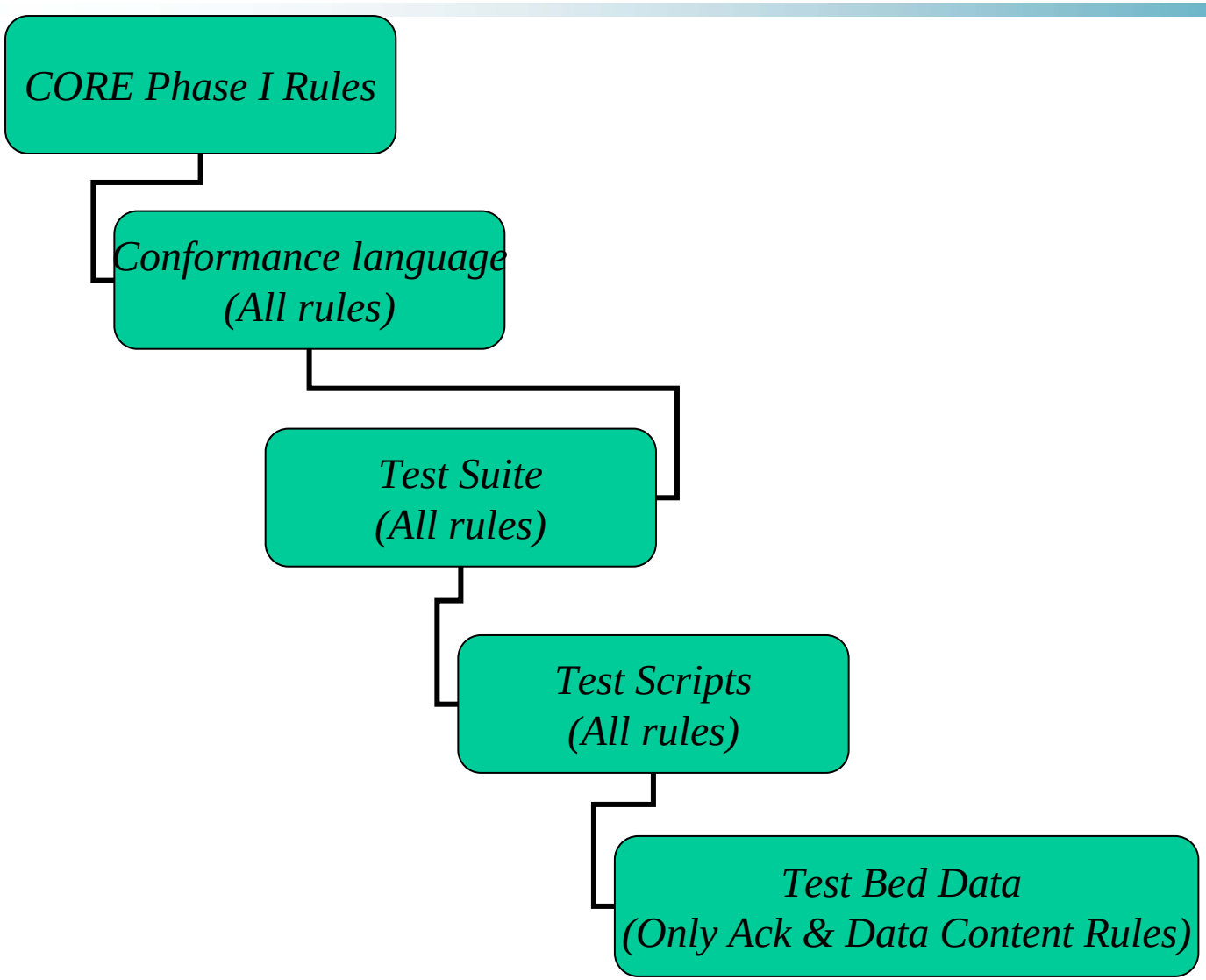
- Steps:

1. Select a CORE-authorized Certification Testing Vendor
2. Enroll with selected vendor
3. Complete certification testing for all applicable rules
4. Complete and submit all required documentation to CORE to obtain CORE Certified Seal

Certification Testing

- Based on Phase I CORE Test Suite
  - For each rule there is standard conformance requirements by stakeholder
  - Suite outlines scenarios and stakeholder-specific test scripts by rule
  - Not testing for HIPAA compliance, only CORE Phase I rules; however, entities must attest that, to the best of their knowledge, they are HIPAA compliant
- Phase I testing is not exhaustive (e.g. does not include production data or volume capacity testing)
- Testing conducted by CORE-authorized certification testing entities
  - CORE RFI issued in Summer 2005; CORE RFP issued in Fall 2005 to identify vendors that were capable of conducting standard CORE-certification testing
  - CORE-authorized certification testing vendors to date
    - Edifecs - Product available at no charge (Please reference 8/16/06 Press Release in binder materials)
  - Vendors under review by CORE
    - Claredi, an Ingenix company

CORE Certification Testing



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CORE Certification Testing Suite

- The CORE Certification Testing Suite uses two master scenarios to describe both the real time and batch business processes for end-to-end insurance verification/eligibility inquiries using business language, not technical specifications
  - Master scenario #1: Single/Dual Clearinghouse Provider-to-Health Plan Model
  - Master scenario #2: Provider Direct to Health Plan Model
- The overall business process for insurance verification/eligibility inquiry does not change from a business viewpoint for each CORE rule. Rather, each CORE rule addresses a critical interoperability activity/task within the common business process
- Using only two master scenarios for all rules simplifies rule test scenario development since the key variables for each rule will be only the actual conformance language of the rule, each test scenario's test objectives, assumptions, and detailed step-by-step test scripts
- Test scenarios for each rule contains the following sections:
  - Actual language of each rule covered by the test scenario
  - Test objectives and certification conformance requirements by rule
  - Test assumptions by rule
  - Detailed step-by-step test scripts addressing each conformance requirement by rule indicating each stakeholder to which the test script applies
  - Each stakeholder may indicate that a specific test script does not apply to it and is required to provide a rationale for indicating a specific test script is not applicable

Real Time Acknowledgements Rule Certification Test Step-by-Step Test Scripts

DETAILED STEP-BY-STEP TEST SCRIPT

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[3]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[4]
1.	A TA1 is returned on an invalid X12 Interchange	An X12 Interchange containing only a TA1 rejecting the entire interchange		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2.	A TA1 is not returned on a valid X12 Interchange	No TA1 is returned		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
3.	A 997 is returned on an invalid Functional Group	An X12 Interchange containing only a 997 FA		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
4.	A 997 is not returned on a valid X12 Interchange	No 997 is returned		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
5.	A 271 Eligibility Response transaction set is always returned for a valid 270 Eligibility Inquiry Transaction set	An X12 Interchange is returned containing only a 271 transaction set		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

Batch Acknowledgements Rule Certification Test Step-by-Step Test Scripts

DETAILED STEP-BY-STEP TEST SCRIPT

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[5]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[6]
1.	A TA1 is returned on an invalid X12 Interchange	An X12 Interchange containing only a TA1 rejecting the entire interchange		☐ Pass	☐ Fail	☒	☒	☒	☒	☐
2.	A TA1 is not returned on a valid X12 Interchange	No TA1 is returned		☐ Pass	☐ Fail	☒	☒	☒	☒	☐
3.	A 997 is returned on an invalid Functional Group	An X12 Interchange containing only a 997 FA		☐ Pass	☐ Fail	☒	☒	☒	☒	☐
4.	A 997 is returned on a valid X12 Interchange	An X12 Interchange containing only a 997 FA		☐ Pass	☐ Fail	☒	☒	☒	☒	☐
5.	A 271 Eligibility Response transaction set is always returned for a valid 270 Eligibility Inquiry Transaction set	An X12 Interchange is returned containing only a 271 transaction set		☐ Pass	☐ Fail	☒	☒	☒	☒	☐

Committee on Operating Rules for Information Exchange (CORE)

Supplement to

CORE Certification Testing Suite Version 1.0.0
Using the CORE Master Test Bed

Version 1.0.0

Applies to

- CORE Rule 154: 270-271 Data Content
- CORE Rule 150: Batch Acknowledgements
- CORE Rule 151: Real Time Acknowledgements

For all other rules please see the CORE Phase I Testing Suite Version 1.0.0

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CORE Master Test Bed Data
(for Acknowledgement and Data Content Rules Only)

- All entities seeking CORE certification will be required to test against the CORE Master Test Bed Data
- Data will be made available to all entities seeking CORE certification for use of pre-certification internal self-testing
- All CORE Authorized Certification Testing Vendors will use the CORE Master Test Bed Data
  - Use of other test data not allowed; use will result in unsuccessful testing
- The CORE Master Test Bed Data comprised of 24 base data cases for several subscribers, dependents and associated health plan coverage
- The base data cases are described in English in the tables in the CORE Certification Testing Suite Supplement
- The CORE Master Test Bed Data is supplied in the ASC X12 Standard Version 004010 valid format using the 270 Eligibility Inquiry and 271 Eligibility Inquiry Response transaction sets for ease of extracting and loading into test databases

Go Live

- Display CORE-Certified Seal

- Announce CORE-Certification to Trading Partners
  - CORE Trading Partner Tool Kit

  (Online at: http://www.caqh.org/CORE_trading.html)

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CORE Deployment Assistance

- CORE Educational Workshops
- CORE website and FAQs
- CAQH staff and technical consultants
- CORE-authorized certification testing vendors
- CORE participants

Internal Benefit Measurements

- Identify opportunity areas
  - Decreased administrative costs
    - Call center
    - Patient registration
    - Claims processing/billing
    - Mail room
    - EDI management
  - Increased satisfaction
    - Trading Partners
    - Patients/Members
      - Meeting expectations
        - » Wait time
        - » Personal financial responsibility
    - Internal Staff
  - Improved financial measures
    - Reduced claims denials
    - Improved POS collections
    - Decreased bad debit
    - Reduced costs
- Implement benefit measurement capabilities
  - Identify “before” costs in selected opportunity areas
  - Review results quarterly
- Ramp up with CORE-certified Trading Partners

In Closing

"The work of CORE is not something that one company – or even one segment of the industry – can accomplish on its own. We will all benefit from the outcome: an easier and better way of communicating with each other."

-- *John W. Rowe, M.D., Executive Chairman of Aetna*

www.CAQH.org